FILE #: _____

CHILD FORMS

CAFE OF LIFE
CHIROPRACTIC

101 Collier Street | Barrie, ON | 705.792.9226

Welcome to Café of Life! Chiropractic care focuses on your child as a whole, including their past health history and birth stressors. Please fill out the following information.

What to expect on your child's FIRST VISIT:

THE CONSULTATION:
The consultation gives us a chance to sit down with you and have a conversation about your child's health concerns (if any), health history, and future health goals. Here we make sure you are in the right place, and for you to learn about what we do and don't do.

THE EXAMINATION:
The purpose of the examination is threefold:

1. To assess the current state of your child's spine and nervous system.
2. Determine if there are any malfunctions of the spine that are directly affecting your child's level of health.
3. Learn what level of care (including frequency) is necessary to achieve optimal health and function and reach your child's health goals.

The examination will include:

Hands on Spine Palpation, Posture Assessment
The chiropractor will be checking their posture and physically examining their spine to locate any areas of malfunction.

Depending on the age of your child, the examination may also include:

Heart Rate Variability
This test measures your child's overall health and adaptability. The more adaptable they are, the faster they will heal.

If, during the exam, there is no indication that further testing is required (for example, x-rays or other imaging), we will proceed with the first adjustment.

What to expect on your child's SECOND VISIT:

On the second visit we will go over any questions you or your child may have, and a care plan personalized to your child and their health needs/goals.

FILE #: _____

BASIC INFORMATION

(Child's)
Name _____ Date _____

Address _____

City/Town _____ Postal Code _____

E-mail Address _____

(Parent's)
Home Ph_____ Business Ph_____ Cell Ph _____

Date of Birth _____d/_____m/_____y/ **Gender** ☐ Male ☐ Female

Parents' Names _____ Siblings Names & Ages _____

How did you hear about us? _____

Current patient's name (if applicable) _____

Indicate the phrase that most represents your child's reason for care:

☐ Wellness ☐ Prevention ☐ Symptom Relief

If there are no specific symptoms or complaints, and your child is mainly here for wellness services, please check (√) here _____ and skip to The Beginning Years.

.

HEALTH CONCERNS

Concern	Rate of Severity 1 = mild 10=worst	When did it start? For how long?	If your child had the condition before, when?	Did the problem begin with an injury?	What % of the time is the pain present?
1.					
2.					
3.					
4.					

Is there a family history of this or similar symptoms? ☐ Yes ☐ No

Please explain: _____

_____

What makes these problems worse?_____

What makes these problems better?_____

Is this condition interfering with your child's:

☐ Eating ☐ Sleep ☐ Daily Routine ☐ Sports/Activities ☐ Other_____

FILE #: _____

Have you made any changes in your child's life due to this pain, illness, condition, etc? (i.e: diet eliminations, herbal medications or other drugs, etc.?) _____

Have you seen anyone else for this condition? _____

☐ Chiropractor ☐ Medical Doctor ☐ Naturopathic Doctor ☐ Other _____

Was it helpful? _____

Has your child ever seen a chiropractor before? If so, were they a:

☐ Symptom Based Chiropractor (focuses only on the pain)

☐ Wellness Chiropractor (focuses on overall function of the spine and nervous system to create health)

THE BEGINNING YEARS

Research is showing that most of the health challenges that occur in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Any childhood illnesses? ☐ Yes ☐ No
Any serious falls as a child? ☐ Yes ☐ No
Did your child play in a jolly jumper? ☐ Yes ☐ No
Did your child play youth sports? ☐ Yes ☐ No
Did your child take/use any drugs? ☐ Yes ☐ No
Did your child have any surgeries? ☐ Yes ☐ No
Has your child fallen/jumped from a height over 3-feet? (crib, bunk bed, tree, etc.) ☐ Yes ☐ No
Was your child involved in any car accidents? ☐ Yes ☐ No
Did your child suffer any other traumas? (physical or emotional) ☐ Yes ☐ No
Were there any prolonged use of medicine, such as antibiotics or an inhaler? ☐ Yes ☐ No
Were they under regular chiropractic care? ☐ Yes ☐ No

PREGNANCY + BIRTH

Tell us more about any stressors at this time in your child's life.

Did mom carry full term? ☐ Yes ☐ No If not, how many weeks gestation? _____
Any complications? ☐ Yes ☐ No If yes, please describe _____
Did you use a: ☐ Midwife ☐ Hospital ☐ Obstetrician
Did mom have a C-Section? ☐ Yes ☐ No
Was there vaccuum extraction? ☐ Yes ☐ No
Did mom have an epidural? ☐ Yes ☐ No
Were there purple markings on their face? ☐ Yes ☐ No
Were foreceps used? ☐ Yes ☐ No
Was mom induced? ☐ Yes ☐ No
Was there an initial respirator delay? ☐ Yes ☐ No
Did they have a mis-shaped skull/head? ☐ Yes ☐ No
Did mom breastfeed? ☐ Yes ☐ No If so, for how long? _____
During the pregnancy, did mom: ☐ Consume Alcohol? ☐ Smoke?
Did mom take any medication during the pregnancy? ☐ Yes ☐ No
Any exposures to Ultrasound? ☐ Yes ☐ No If yes, how many? _____

FILE #: _____

Have any of the following conditions affected your child *chronically* (in the past and/or present):

☐ Allergies	☐ Asthma	☐ Sinus Problems	☐ Eczema	☐ Frequent Colds	☐ Confusion
☐ Diarrhea	☐ Constipation	☐ Growing Pains	☐ Heartburn	☐ Frequent Fevers	☐ Tonsilitis
☐ Frequent Nausea	☐ Chronic Infections	☐ Frequent Crying	☐ Balance Problems	☐ Bladder Trouble	☐ Diabetes
☐ Scoliosis	☐ Forgetfulness	☐ Mood Swings	☐ Trouble Gaining Weight	☐ Bed Wetting	☐ Dizziness
☐ Stomach Problems	☐ Colic	☐ Sleeping Problems	☐ Hyper Activity / Autism	☐ Headaches	☐ Anxiety
☐ Heart/Vascular Problems	☐ Leg/Knee Pain	☐ Fatigue	☐ Anemia	☐ Learning Difficulties	☐ Depression

Other (please explain)_____

_____

_____

Has your child received all suggested vaccinations? ☐ Yes ☐ No

If no, which were omitted or postponed? _____

_____

Any reactions to vaccinations? ☐ Yes ☐ No

Is there anything else that you would like to tell us, to help us understand you and your child's health concerns or goals?

_____

_____

_____

FILE #: _____

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at the Café of Life will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At Café of Life, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

Consent to assess and adjust a minor (under 16):

I, _____, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_____ have read and fully understand the above terms of acceptance and
(CHILD'S NAME) hereby grant permission for my child to receive chiropractic care.